Communicable Disease Provider Packet

Developed by the Long Beach Department of Health and Human Services, HIV and STD Surveillance Program

January 2017

LONG BEACH
HEALTH & HUMAN SERVICES

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1 REPORTING

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REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR) §2500

It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

URGENCY REPORTING REQUIREMENTS

☎=Report immediately by telephone ✉=Report within 1 working day Report within 7 calendar days from time of identification

REPORTABLE DISEASES

✉ Amebiasis
Anaplasmosis
☎ Anthrax
✉ Babesiosis
☎ Botulism (Infant, Foodborne, Wound)
Brucellosis, animal (except infections due to *Brucella canis*)
☎ Brucellosis, human
✉ Campylobacteriosis
Chancroid
✉ Chickenpox (Varicella), (outbreaks, hospitalizations and deaths)
✉ Chikungunya Virus Infection
Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
☎ Cholera
☎ Ciguatera Fish Poisoning
Coccidioidomycosis
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
✉ Cryptosporidiosis
Cyclosporiasis
Cysticercosis or Taeniasis
☎ Dengue Virus Infection
☎ Diphtheria
☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
Ehrlichiosis
✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
☎ *Escherichia coli:* shiga toxin producing (STEC) including *E. coli* O157
☎ Flavivirus Infection of Undetermined Species
✉ Foodborne Disease
Giardiasis
Gonococcal Infections
✉ Haemophilus *influenza,* invasive disease, all serotypes (report an incident of less than 5 years of age)
✉ Hantavirus Infections
☎ Hemolytic Uremic Syndrome
⑦ Hepatitis, Viral
✉ Hepatitis A
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta) (specify acute case or chronic)
Hepatitis E, acute infection
Human Immunodeficiency Virus (HIV) Infection, stage 3 (AIDS)
Human Immunodeficiency Virus (HIV), Acute Infection
Influenza, deaths in lab-confirmed cases age 0-64 years
☎ Influenza, novel strains (human)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
✉ Listeriosis
Lyme Disease
✉ Malaria
☎ Measles (Rubeola)
✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
☎ Meningococcal Infections
Mumps
☎ Novel Virus Infection with Pandemic Potential
☎ Paralytic Shellfish Poisoning
✉ Pertussis (Whooping Cough)
☎ Plague, Human or Animal
✉ Poliovirus Infection
✉ Psittacosis
✉ Q Fever
☎ Rabies, Human or Animal
✉ Relapsing Fever
Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
Respiratory Syncytial Virus (only report a death in a patient less than five years of age)
✉ Salmonellosis (Other than Typhoid Fever)
☎ Scombroid Fish Poisoning
☎ Shiga toxin (detected in feces)
✉ Shigellosis
☎ Smallpox (Variola)
✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
✉ Syphilis
Tetanus
✉ Trichinosis
✉ Tuberculosis†
Tularemia, animal
☎ Tularemia
✉ Typhoid Fever, Cases and Carriers
✉ *Vibrio* Infections
☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
✉ West Nile Virus (WNV) Infection
☎ Yellow Fever
✉ Yersiniosis
☎ Zika Virus Infection
☎ **OCCURRENCE of ANY UNUSUAL DISEASE**
☎ **OUTBREAKS of ANY DISEASE**
(Including diseases not listed in §2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, §2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

✉ Positive Skin Tests in Children Less Than 3 years of Age Without History of BCG Vaccination;
✉ *Norovirus* in Food Employees

To report a case or outbreak of any disease contact the Epidemiology Program:
Phone: (562) 570-4302 • Fax: (562) 570-4374 • After Hours: (562) 435-6711

* Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.
CDPH 110a (revised 7/2016)

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director

EDMUND G. BROWN JR.
Governor

June 15, 2012

To All California Health Care Providers:

Re: HIPAA and Public Health Disclosures

Dear Health Care Provider,

There has been some confusion surrounding the effect of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule on public health reporting requirements. Therefore, the California Department of Public Health is providing this document to clarify your ongoing legally mandated reporting requirements.

Your reporting obligations for communicable diseases have not changed under HIPAA. Furthermore, you continue to have a legal obligation to provide information for public health, surveillance/reporting, investigations and interventions.

The HIPAA Privacy Rule (at 45 Code of Federal Regulations, § 160.203(c) indicates that State law, including State procedures established under such law, is not preempted or overridden by contrary HIPAA privacy provisions in the area of public health disease or injury reporting and the conduct of public health surveillance, investigation, or intervention. The following provisions of State law are applicable and are not preempted by HIPAA:

Under California law, health care providers are required to report specified diseases or conditions to the local health officer for the jurisdiction where the patient resides. (Cal. Code Regulations, title 17, § 2500.) The State and local health departments are authorized by law to conduct infectious disease investigations and interventions. Upon receiving a report of a disease, the local health officer must take whatever steps are deemed necessary for the investigation and control of the disease, condition or outbreak reported. (Cal. Code Regulations, title 17, § 2501.) Further, local health officers must prepare individual case and outbreak reports and provide these to the State Department of Public Health. It is mandatory to supply personal health information related to the individual's disease to the local health officer who collects the information in order to prepare such case reports. (Cal. Code Regulations, title 17, § 2502(g)). The authority of local health officers with respect to reportable and communicable diseases is spelled out in the Health and Safety Code, § 120175:

"Each health officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the department, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases."

With respect to sexually transmitted diseases, Health and Safety Code, § 120575 provides:

"It is the duty of the local health officers to use every available means to ascertain the existence of cases of infectious venereal diseases within their respective jurisdictions, to investigate all cases that are not, or probably are not, subject to proper control measures approved by the board, to ascertain so far as possible all sources of infection, and to take all measures reasonably necessary to prevent the transmission of infection."

State law also makes it a misdemeanor if you do not provide the requested information to aid in the conduct of the investigation of sexually transmitted diseases. (Health & Safety Code, §120600.)

The California Department of Public Health appreciates your cooperation in continuing to protect the health, safety, and privacy of all Californians and stands ready to help you in these challenging times with data, security and privacy requirements.

If you have any further questions, we advise you to contact your local attorney. You may also contact Dr. Bauer directly at the number or email below.

Sincerely,

Heidi Bauer, M.D., M.P.H.
Chief, STD Control Branch
(510) 620-3178
Heidi.bauer@cdph.ca.gov.

Stephen A. Stuart
Senior Counsel and Privacy Officer
Privacy Office, Office of Legal Services
(916) 440-7432 or (877) 421-9634
Stephen.Stuart@CDPH.ca.gov
or Privacy@CDPH.ca.gov

2 STD REPORTING

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CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | *First Name* | *MI*

Home Address: Number, Street | *Apt./Unit No.*

City | *State* | *ZIP Code*

Home Telephone Number | *Cell Telephone Number* | *Work Telephone Number*

Email Address | *Primary Language* ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | *Age* ☐ Years ☐ Months ☐ Days | *Gender* ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | *Est. Delivery Date (mm/dd/yyyy)* | *Country of Birth*

Occupation or Job Title

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset (mm/dd/yyyy) | *Date of First Specimen Collection (mm/dd/yyyy)* | *Date of Diagnosis (mm/dd/yyyy)* | *Date of Death (mm/dd/yyyy)*

Reporting Health Care Provider | *Reporting Health Care Facility*

Address: Number, Street | *Suite/Unit No.*

City | *State* | *ZIP Code*

Telephone Number | *Fax Number*

Submitted by | *Date Submitted (mm/dd/yyyy)*

REPORT TO:

City of Long Beach
Department of Health & Human Services
Epidemiology Program
2525 Grand Avenue, Room 201
Long Beach, CA 90815
Phone: (562) 570-4302
Fax: (562) 570-4374

(Obtain additional forms from your local health department.)

Laboratory Name | *City* | *State* | *ZIP Code*

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

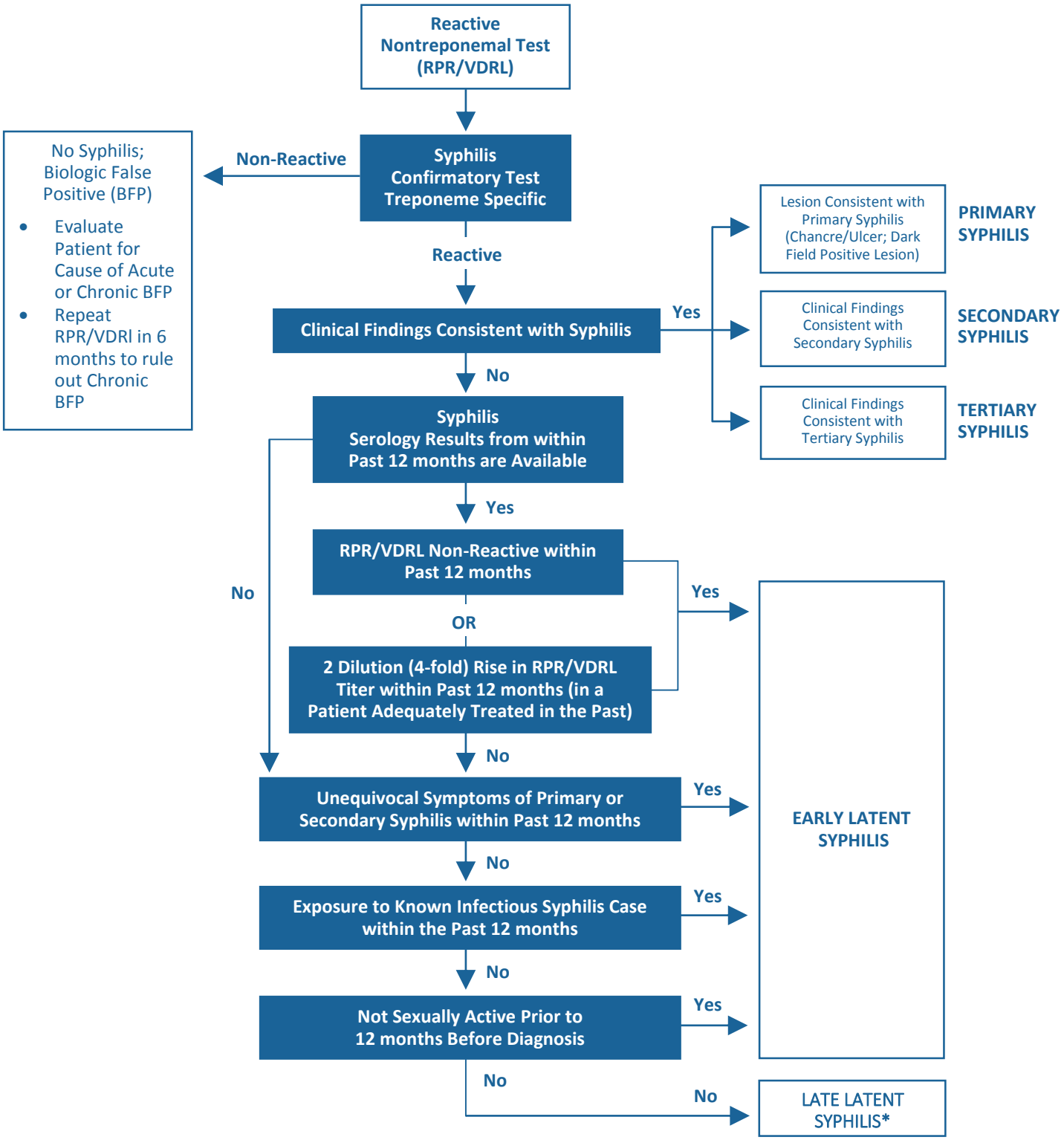
ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

FIGURE 1: Syphilis Diagnosis Algorithm



Patients who deny any history of signs/symptoms of syphilis or history of known exposure to a case of infectious syphilis, and for whom it is unclear when the exposure occurred, are often managed medically as a case of **LATE LATENT SYPHILIS, although more accurately it represents "LATENT SYPHILIS OF UNKNOWN DURATION."*

FIGURE 2: Treatment Table for Syphilis Infection in NON-Pregnant Adults

STAGE [Onset post-exposure]	CONSIDERED INFECTIOUS	HIV STATUS	TREATMENT	AT RISK PARTNER(S)
Primary [3-90 days, average 21 days]	YES		IM benzathine penicillin G 2.4 million units- single injection Some experts recommend additional doses in HIV- positive patients (eg. Intramuscular benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units each at 1 week intervals, although the formal CDC recommendation is for a single injection of 2.4 mU. <u>CDC recommended alternatives for Non-pregnant patients with a documented penicillin allergy</u> Oral doxycycline 100mg twice each day x 2 weeks **OR** Oral tetracycline 500mg four times a day x 2 weeks **OR** ceftriaxone IM or IV 1g daily x 8-10 day	Partners exposed up to 3 months prior to first symptom.
Secondary [1.5 - 6 months]	YES		SEE Treatment of Primary Syphilis	Partners exposed up to 6 months prior to first symptom.
Early Latent [≤ 1 year]	YES		SEE Treatment of Primary Syphilis	Partners exposed up to 12 months prior to first symptom.
Late Latent [> 1 year]	NO	HIV Negative	IM benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units each at 1 week intervals <u>CDC</u> recommended alternatives for nonpregnant patients with a documented penicillin allergy Oral doxycycline 100mg twice each day x 4 weeks **OR** Oral tetracycline 500mg four times a day x 4 weeks	Evaluate spouses and long-term partners clinically and serologically. Children born outside of the U.S. should be evaluated to rule out congenital infection.
		HIV Positive	IM benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units each at 1 week intervals	
Latent Syphilis Of Unknown Duration [??]	Possibly		Since the duration of infection is uncertain, therapy of maximal duration is recommended (SEE Late Latent Syphilis, above)	
Tertiary [months- yrs]	NO		SEE Late Latent Syphilis (above)	See Late Latent (above)
Neurosyphilis			Aqueous crystalline penicillin G 18-24 million units daily, administered as 3-4 million units IV q 4 hrs for 10-14 days. **OR** Procaine penicillin 2.4 million units IM qd **PLUS** probenecid 500 mg orally 4 times daily, both for 10-14 days.	

** SEE CDC recommended guidelines for patient follow-up or additional treatment questions.*

CITY OF LONG BEACH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2525 Grand Ave. Long Beach, CA 90815 (562) 570-4302 FAX (562) 570-4374

Mauro Torno, MD
Interim City Health Officer

EPIDEMIOLOGY/
COMMUNICABLE DISEASE CONTROL PROGRAM

September 15, 2016

SUBJECT: Syphilis Testing and Treatment

Dear Health Care Provider,

For testing and diagnosis of syphilis, two serological tests are required:

1) A nontreponemal antibody test (RPR)
2) A treponemal antibody test (either TP-PA or FTA-ABS)

For ease of testing, we recommend ordering the RPR with reflex to titer and confirmatory testing or ordering both tests (RPR and treponemal) simultaneously. At this time, both Lab Corp and Quest Diagnostics offer the reflex option:

Lab Corp: Rapid Plasma Reagin (RPR) Test With Reflex to Quantitative RPR and Confirmatory *Treponema pallidum* Antibodies

Quest Diagnostics: RPR (Diagnosis) with Reflex to Titer and Confirmatory Testing

Both tests are required as the RPR detects antibodies that are not specifically directed against the *Treponema pallidum* bacterium. Reactive RPRs may be a biological false positive and require the treponemal test for confirmation.

For syphilis treatment, see attached California Department of Public Health (CDPH) guidelines.

Additional Resources from CPDH Sexually Transmitted Diseases Guidelines Webpage:

- California STD Treatment Guidelines for Adults and Adolescents, 2015 (2-page Summary) (PDF)
- CDC Treatment Guidelines 2015
- Treponemal Immunoassays For Syphilis Diagnosis and Screening

Main Link to CPDH Guidelines:
http://www.cdph.ca.gov/pubsforms/Guidelines/Pages/SexuallyTransmittedDiseasesScreeningandTreatmentGuidelines.aspx

If you have any questions regarding testing or treatment, please contact Belinda Prado of the Long Beach Health Department.

Belinda Prado
HIV/STD Surveillance Coordinator
(562) 570-4213
Belinda.Prado@longbeach.gov

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for the public health investigation of communicable disease (Title 17, California Code of Regulations, Section 2500). Reliance on laboratory reporting is NOT a substitute. Under State laws, the reporting of communicable diseases to the local public health department is exempt from HIPAA (Section 164.512 (b)). **Patient consent is not required**. Patient information is always treated with strict confidence, and information requested is the minimum necessary for public health purposes.

CALIFORNIA STD TREATMENT GUIDELINES TABLE FOR ADULTS & ADOLESCENTS 2015

These guidelines reflect recent updates in the 2015 CDC STD Treatment Guidelines for both HIV-uninfected and HIV-infected adults and adolescents; treatments that differ for HIV-infected populations are designated by a red ribbon. Call the local health department for assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection. For STD clinical management consultation, call (510-620-3400) or submit your question online to the STD Clinical Consultation Network at www.stdccn.org

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen.
CHLAMYDIA (CT)			
Genital/Rectal/Pharyngeal Infections[1]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Levofloxacin[2] 500 mg po qd x 7 d **or** • Ofloxacin[2] 300 mg po bid x 7 d **or** • Doxycycline[2] (delayed release) 200 mg po qd x 7 d
Pregnant Women[3]	• Azithromycin	1g po	• Amoxicillin[4] 500 mg po tid x 7 d **or** • Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin base 250 mg po qid x 14 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA (GC): Dual therapy with ceftriaxone 250 mg IM PLUS azithromycin 1 g po is recommended for all patients with gonorrhea regardless of chlamydia test results.[5] Dual therapy should be simultaneous and by directly observed therapy. Azithromycin is preferred second antimicrobial; if allergy to azithromycin, can use doxycycline 100 mg po bid x 7 days.			
Genital/Rectal Infections[1,5]	Dual therapy with • Ceftriaxone PLUS • Azithromycin	250 mg IM 1 g po	Dual therapy with • Cefixime[6] 400 mg po PLUS Azithromycin 1 g po **or** Doxycycline 100 mg po bid x 7 d **Cephalosporin allergy or IgE mediated penicillin allergy** • Gemifloxacin[2] 320 mg po PLUS Azithromycin 2 g po **or** • Gentamicin[2] 240 mg IM PLUS Azithromycin 2 g po
Pharyngeal Infections[5]	Dual therapy with • Ceftriaxone PLUS • Azithromycin	250 mg IM 1 g po	If cephalosporin allergy or IgE mediated penicillin allergy (e.g., anaphylaxis, Stevens-Johnson syndrome, or toxic epidermal necrolysis), limited data exist on alternatives. See footnotes.[7]
Pregnant Women[3,5]	Dual therapy with • Ceftriaxone PLUS • Azithromycin	250 mg IM 1 g po	• Cefixime[6] 400 mg po PLUS • Azithromycin 1g po If cephalosporin allergy or IgE mediated penicillin allergy, consult with specialist, see footnotes.[3]
PELVIC INFLAMMATORY DISEASE[8,9] *(Etiologies: CT, GC, anaerobes, possibly M. genitalium, others)*	Parenteral • Either Cefotetan **or** Cefoxitin **plus** Doxycycline[2] **or** • Clindamycin **plus** Gentamicin IM/Oral • Either Ceftriaxone **or** Cefoxitin with Probenecid **plus** Doxycycline[2] **plus** Metronidazole if BV is present or cannot be ruled out	 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	Parenteral • Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs Oral[10] • Levofloxacin[2] 500 mg po qd x 14 d **or** • Ofloxacin[2] 400 mg po bid x 14 d **or** • Moxifloxacin[2] 400 mg po qd x 14 d **or** • Ceftriaxone 250 mg IM in a single dose **plus** Azithromycin 1 g po once a week for 2 weeks **plus** • Metronidazole 500 mg po bid x 14 d if BV is present or cannot be ruled out
CERVICITIS[8,11,12] *(Etiologies: CT, GC, T. vaginalis, HSV, possibly M. genitalium)*	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	
NONGONOCOCCAL URETHRITIS (NGU)[8,12]	• Azithromycin **or** • Doxycycline	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Levofloxacin 500 mg po qd x 7 d **or** • Ofloxacin 300 mg po bid x 7 d
RECURRENT/PERSISTENT NGU (*Etiolgies: M. genitalium T.vaginalis, other bacteria)*[12]	• Moxifloxacin **plus** • Metronidazole[12] or • Tinidazole[12]	400 mg po qd x 7d 2 g po 2 g po	
EPIDIDYMITIS[8]	Likely due to GC or CT • Ceftriaxone **plus** Doxycycline Likely due to GC, CT or enteric organisms (history of anal insertive sex) • Ceftriaxone **plus** • Levofloxacin **or** • Ofloxacin Likely due to enteric organisms • Levofloxacin[13] **or** • Ofloxacin[13]	250 mg IM 100 mg po bid x 10 d 250 mg IM 500 mg po qd x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d 300 mg po bid x 10 d	
LYMPHOGRANULOMA VENEREUM	• Doxycycline[2]	100 mg po bid x 21 d	• Erythromycin base 500 mg po qid x 21 d
TRICHOMONIASIS[14,15]			
Adults/Adolescents	• Metronidazole **or** • Tinidazole[16]	2 g po 2 g po	• Metronidazole 500 mg po bid x 7 d
Pregnant Women	• Metronidazole	2 g po	
HIV-infected Women	• Metronidazole	500 mg po bid x 7 d	

[1] Annual screening is recommended for women aged < 25 years. Nucleic acid amplification tests (NAATs) are recommended. All patients should be re-tested 3 months after treatment for CT or GC.
[2] Contraindicated for pregnant and nursing women.
[3] Every effort should be made to use a recommended regimen. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy. In case of allergy to both alternative and recommended regimens, consult with the CA STD Control Branch at at 510-620-3400 or the STD Clinical Consultation Network at www.stdccn.org
[4] Amoxicillin is now an alternative regimen due to chlamydial persistence in animal and in vitro studies.
[5] If the patient has been treated with a recommended regimen for GC, reinfection has been ruled out, and symptoms have not resolved, perform a test-of-cure using culture and antibiotic susceptibility testing and report to the local health department. For clinical consult and for help in obtaining GC culture call the CA STD Control Branch at 510-620-3400. For specific treatment guidance, go to www.std.ca.gov ("STD Guidelines, California Gonorrhea Treatment Guidelines --- Suspected Gonorrhea Treatment Failure").
[6] Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone 250 mg; limited efficacy for treating pharyngeal GC. Cefixime should only be used when ceftriaxone is not available.
[7] Dual therapy with gemifloxacin 320 mg po plus azithromycin 2 g po or gentamicin 240 mg IM plus azithromycin 2 g po are potential alternatives. ID specialist consult may be prudent. Azithromycin monotherapy is no longer recommended due to resistance concerns and treatment failure reports. Pharyngeal GC patients treated with an alternative regimen should have a test of cure (with culture or NAAT) 14 days after treatment.
[8] Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management and because these infections are reportable by state law.
[9] Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole. If parenteral therapy is selected, discontinue 24-48 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
[10] In the setting of allergy to cephalosporins, fluoroquinolones can be considered for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient can be assured. If GC is documented, the patient should be re-treated based on antimicrobial susceptibility test results (if available). If antimicrobial susceptibility testing reveals fluoroquinolone resistance or if testing is unavailable then consultation with ID specialist is recommended for treatment options.
[11] If patient lives in community with high GC prevalence, or has risk factors (e.g. age <25 years, new partner, partner with concurrent sex partners, or sex partner with a STD), consider empiric treatment for GC.
[12] Mycoplasma genitalium causes urethritis and possibly cervicitis that can persist despite treatment with azithromycin. Moxifloxacin 400 mg orally for 7 days is recommended for persistent NGU in men and can be considered for persistent cervicitis in women. In areas of high T. vaginalis prevalence, men who have sex with women (MSW) with persistent urethritis should also be treated for T. vaginalis.
[13] Gonorrhea should be ruled out prior to starting a fluroquinolone-based regimen.
[14] For suspected drug-resistant trichomoniasis, rule out re-infection; see 2015 CDC Guidelines, Persistent or Recurrent Trichomonas section, for other treatment options, and evaluate for metronidazole-resistant *T. vaginalis*. For consultation call (510-620-3400) or contact the STD Clinical Consultation Network at www.stdccn.org
[15] All women should be retested for trichomoniasis 3 months after treatment.
[16] Safety in pregnancy has not been established; avoid during pregnancy. When using tinidazole, breastfeeding should be deferred for 72 hours after 2 g dose.

Developed by the California Prevention Training Center and
California Department of Public Health STD Control Branch
Updated November 2015

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
BACTERIAL VAGINOSIS			
Adults/Adolescents	• Metronidazole **or** • Metronidazole gel **or** • Clindamycin cream[17]	500 mg po bid x 7 d 0.75%, one full applicator (5 g) Intravaginally qd x 5 d 2%, one full applicator (5 g) Intravaginally qhs x 7 d	• Tinidazole[16] 2 g po qd x 2 d **or** • Tinidazole[16] 1 g po qd x 5 d **or** • Clindamycin 300 mg po bid x 7 d **or** • Clindamycin ovules[17] 100 mg intravaginally qhs x 3 d
Pregnant Women	• Metronidazole **or** • Metronidazole gel **or** • Clindamycin cream[17]	500 mg po bid x 7 d 0.75%, one full applicator (5 g) Intravaginally qd x 5 d 2%, one full applicator (5 g) Intravaginally qhs x 7 d	• Clindamycin 300 mg po bid x 7 d **or** • Clindamycin ovules[17] 100 mg intravaginally qhs x 3 d
ANOGENITAL WARTS			
External Genital/Perianal Warts	Patient-Applied • Imiquimod[17,18] 5% cream **or** • Imiquimod[17,18] 3.75% cream **or** • Podofilox[16] 0.5% solution or gel **or** • Sinecatechins[16,17] 15% ointment Provider-Administered • Cryotherapy **or** • Trichloroacetic acid (TCA) 80%-90% **or** • Bichloroacetic acid (BCA) 80%-90% **or** • Surgical removal	Topically qhs 3 times/ wk up to 16 wks Topically qhs up to 16 wks Topically bid x 3 d followed by 4 d no tx for up to 4 cycles Topically tid, for up to 16 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks	Alternative Regimen – Provider Administered • Podophyllin resin[16,19] 10%-25% in tincture of benzoin apply q 1-2 wks **or** • Intralesional interferon **or** • Photodynamic therapy **or** • Topical cidofovir
Mucosal Genital Warts[20]	• Cryotherapy **or** • Surgical removal **or** • TCA or BCA 80%-90%	Vaginal, urethral meatus, cervical, anal Vaginal, urethral meatus, cervical, anal Vaginal, cervical, anal	
ANOGENITAL HERPES[21]			
First Clinical Episode of Anogenital Herpes	• Acyclovir **or** • Acyclovir **or** • Valacyclovir **or** • Famciclovir	400 mg po tid x 7-10 d 200 mg po 5x/day x 7-10 d 1 g po bid x 7-10 d 250 mg po tid x 7-10 d	
Established Infection Suppressive Therapy[22] Suppressive Therapy for Pregnant Women (start at 36 weeks gestation) Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Valacyclovir **or** • Valacyclovir **or** • Famciclovir[22] • Acyclovir **or** • Valacyclovir • Acyclovir **or** • Acyclovir **or** • Acyclovir **or** • Valacyclovir **or** • Valacyclovir **or** • Famciclovir **or** • Famciclovir **or** • Famciclovir	400 mg po bid 500 mg po qd 1 g po qd 250 mg po bid 400 mg po tid 500 mg po bid 400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d 500 mg po bid x 3 d 1 g po qd x 5 d 125 mg po bid x 5 d 1g po bid x 1 d 500 mg po once, then 250 mg bid x 2 d	
HIV Co-Infected[23]			
Suppressive Therapy[22]	• Acyclovir **or** • Valacyclovir **or** • Famciclovir[22]	400-800 mg po bid or tid 500 mg po bid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Valacyclovir **or** • Famciclovir	400 mg po tid x 5-10 d 1g po bid x 5-10 d 500 mg po bid x 5-10 d	
SYPHILIS[24,25]			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• Doxycycline[26] 100 mg po bid x 14 d **or** • Tetracycline[26] 500 mg po qid x 14 d **or** • Ceftriaxone[26] 1 g IM or IV qd x 10-14 d
Late Latent	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• Doxycycline[26] 100 mg po bid x 28 d **or** • Tetracycline[26] 500 mg po qid x 28 d
Neurosyphilis and Ocular Syphilis[27]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d **or** • Ceftriaxone[26] 2 g IM or IV qd x 10-14 d
Pregnant Women[28] NOTE: Pregnant women who miss any dose of therapy must repeat full course of treatment.			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• None
Late Latent	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• None
Neurosyphilis and Ocular Syphilis[27]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d

[16] Safety in pregnancy has not been established; avoid during pregnancy. When using tinidazole, breastfeeding should be deferred for 72 hours after 2 g dose.
[17] May weaken latex condoms and contraceptive diaphragms. Patients should follow directions on package insert carefully regarding whether to wash area after treatment (e.g. imiquimod) versus leaving product on the affected area (e.g. sinecatechins).
[18] Limited human data on imiquimod use in pregnancy; animal data suggest low risk.
[19] Podophyllin resin is now an alternative rather than recommended regimen; severe toxicity has been reported.
[20] Cervical and intra-anal warts should be managed in consultation with specialist.
[21] Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
[22] The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission. Famciclovir is somewhat less effective for suppression of viral shedding.
[23] If HSV lesions persist or recur during antiviral treatment, drug resistance should be suspected. Obtaining a viral isolate for sensitivity testing and consulting with an infectious disease expert is recommended.
[24] Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
[25] Persons with HIV infection should be treated according to the same stage-specific recommendations for primary, secondary, and latent syphilis as used for HIV-negative persons. Available data demonstrate that additional doses of benzathine penicillin G, amoxicillin, or other antibiotics in early syphilis do not result in enhanced efficacy, regardless of HIV status.
[26] Alternates should be used only for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.
[27] Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.
[28] Pregnant women allergic to penicillin should be desensitized and treated with penicillin. There are no alternatives. Pregnant women who miss any dose of therapy (greater than 7 days between doses) must repeat the full course of treatment.

Developed by the California Prevention Training Center and California Department of Public Health STD Control Branch
Updated November 2015

3 HIV REPORTING

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ADULT HIV/AIDS CASE REPORT FORM
(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Information

(Record All Dates as mm/dd/yyyy) ***Shaded Fields are Required.***

Name of Person Completing Form:	Person's Phone Number: ( )	STATENO:	CITYNO:
Date Form Completed: _____/_____/_____	Reporting Health Department - City/County:	Document Source:	
Report Status: ☐ 1- New ☐ 2- Update	Physician's Name:	Physician's Phone Number: ( )	Hospital/Facility Name:
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Surveillance Method: ☐ Active ☐ Passive ☐ Follow Up ☐ Reabstraction ☐ Unknown	Report Medium: ☐ 1- Field Visit ☐ 2- Mailed ☐ 3- Phone ☐ 4- Electronic Transfer ☐ 5- CD/Disk	

II. Patient Identification

Patient Last Name:	Middle Name:	First Name:		
Alternate Name Type *(e.g. Alias, Married, etc.)*:	Last Name:	Middle Name:	First Name:	
Address Type: ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary				
Current Street Address:	City:	County:		
State/Country:	ZIP Code:	Phone Number: ( )	Social Security Number:	Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:		

III. Patient Demographics *(See Appendix 2.0 for Further Details)* *(Record All Dates as mm/dd/yyyy)*

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Unknown	Country of Birth: ☐ U.S. ☐ Other/U.S. Dependency *(please specify)*: _____	Date of Birth: _____/_____/_____		
Alias Date of Birth: _____/_____/_____	Vital Status: ☐ 1- Alive ☐ 2- Dead	Date of Death: _____/_____/_____	State of Death:	Status: ☐ HIV ☐ AIDS

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender: Male-to-Female (MTF) ☐ Transgender: Female-to-Male (FTM) ☐ Unknown ☐ Other Gender Identity *(specify)*: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity:
Expanded Race:	

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander
☐ Chinese ☐ Vietnamese ☐ Hawaiian
☐ Japanese ☐ Asian Indian ☐ Guamanian
☐ Filipino ☐ Laotian ☐ Samoan
☐ Korean ☐ Cambodian
☐ Other *(specify)*: _____

IV. Residence at Diagnosis *(See Appendix 3.0 for Further Details - Add Additional Addresses in Comments and Local/Optional Fields Section)* *(Required as Appropriate Based on Status)*

Address Type *(check all that apply)*: ☐ Residence at HIV Diagnosis ☐ Residence at AIDS Diagnosis ☐ Check if SAME as Current Address

	Street Address:	City:	County:	State/Country:	ZIP Code:
Address of Residence at HIV Diagnosis					
Address of Residence at AIDS Diagnosis					

V. Facility at Diagnosis *(See Appendix 4.0 for Further Details - Add Additional Facilities in Comments and Local/Optional Fields Section)* STATENO:_____

Diagnosis Type *(check all that apply to facility):* ☐ HIV Diagnosis ☐ AIDS Diagnosis ☐ Check if SAME as Facility Providing Information

Facility Name:	Phone Number: ( )	Street Address:	City:

County:	State/Country:	ZIP Code:	Provider Name:

Facility Type:

Inpatient: ☐ Hospital ☐ Other *(specify):* _____

Outpatient: ☐ Private Physician ☐ Adult HIV Clinic ☐ Other *(specify):* _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other *(specify):* _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other *(specify):* _____

VI. Patient History *(See Appendix 5.0 for Further Details - Respond to All Questions)*

☐ **Pediatric Risk** *(Please Enter in Comments and Local/Optional Fields Section)*

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:

Sex with a male: ☐ Yes ☐ No ☐ Unknown Sex with a female: ☐ Yes ☐ No ☐ Unknown Injected non-prescription drugs: ☐ Yes ☐ No ☐ Unknown

HETEROSEXUAL relations with any of the following:	**Has the patient:**
Contact with intravenous/injection drug user (IDU): ☐ Yes ☐ No ☐ Unknown	Received clotting factor for hemophilia/coagulation disorder: ☐ Yes ☐ No ☐ Unknown
Contact with a bisexual male: ☐ Yes ☐ No ☐ Unknown	Received transfusion of blood/blood components *(non-clotting)*: ☐ Yes ☐ No ☐ Unknown
Contact with a person with AIDS or documented HIV infection, risk not specified: ☐ Yes ☐ No ☐ Unknown	Other documented risk: *(if yes, specify):* ☐ Yes ☐ No ☐ Unknown
Contact with transplant recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	_____
Contact with transfusion recipient with documented HIV: ☐ Yes ☐ No ☐ Unknown	

VII. Laboratory Data *(Record All Dates as mm/dd/yyyy) (See Instructions for Details)*

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]

TEST 1: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST 2: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

TEST 3: ☐ HIV-1 EIA ☐ HIV-1/2 EIA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 EIA ☐ HIV-2 WB
☐ Other *(specify test):* _____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **RAPID TEST** *(check if rapid):* ☐ **Collection Date**: ____/____/_____
Manufacturer: _____

HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]

TEST: ☐ HIV-1/2 Differentiating *(e.g. Multispot)*

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both *(undifferentiated)* ☐ Neither *(negative)* **Collection Date**: ____/____/_____

VII. Laboratory Data *(continued)* *(Record All Dates as mm/dd/yyyy)*

STATENO:_____

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Qual)* ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT *(Qual)* ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date**: ____/____/_____

HIV Detection Tests (Quantitative Viral Load) ***Note: Include earliest test after diagnosis***

TEST 1: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

TEST 2: ☐ HIV-1 RNA/DNA NAAT *(Quantitative Viral Load)* ☐ RT-PCR ☐ bDNA ☐ Other *(specify test)*: _____

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL**: _____ **Log**: _____ **Collection Date**: ____/____/_____

Immunologic Tests (CD4 Count and Percentage)

CD4 at or closest to current diagnosis status: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

First CD4 result <200 cells/µL or <14%: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

Other CD4 result <200 cells/µL or <14%: **CD4 count:** _____ cells/µL **CD4 percentage:** _____ % **Collection Date**: ____/____/_____

Documentation of Tests *(Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA])*

Did documented laboratory test results meet approved HIV diagnostic algorithm? ☐ Yes ☐ No ☐ Unknown

If yes, provide date *(specimen collection date if known)* of earliest positive test for this algorithm: ____/____/_____

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of documentation by physician: ____/____/_____

VIII. Clinical *(Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)*

	✓	Date		✓	Date
Candidiasis, esophageal			Kaposi's sarcoma		
Cryptococcosis, extrapulmonary			Pneumocystis carinii pneumonia		
Cytomegalovirus disease (other than in liver, spleen or nodes)			Wasting syndrome due to HIV		
Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis			Other *(specify)*:		

IX. Treatment/Services Referrals *(Record All Dates as mm/dd/yyyy)*

Has This Patient Been Informed of His/Her HIV Infection? ☐ Yes ☐ No ☐ Unknown

Patient's Medical Treatment is Primarily Reimbursed by:

☐ 1- Medicaid ☐ 2- Private Insurance/HMO ☐ 3- No Coverage ☐ 4- Other Public Funding ☐ 9- Unknown

For Female Patient:

Is This Patient Currently Pregnant? ☐ Yes ☐ No ☐ Unknown

Has This Patient Delivered Live-Born Infants? ☐ Yes ☐ No ☐ Unknown

IX. Treatment/Services Referrals *(continued)* *(Record All Dates as mm/dd/yyyy)*

STATENO:_____

For Children of Patient: *(Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)*		
Child's Name:	Child's Soundex:	Child's Date of Birth: _____/_____/_____
Child's Coded ID:	Child's STATENO:	
Hospital of Birth: *(If Child Was Born at Home, Enter "Home Birth" for Hospital Name)*		
Hospital Name:		Phone Number: ( )
Street Address:	City:	
County:	State/Country:	ZIP Code:

X. HIV Testing and Antiretroviral Use History (TTH) *(Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)*

Main Source of Testing and Treatment History Information *(select one):* ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other *(specify):* _____			Date Patient Reported Information: _____/_____/_____
Ever Had a Positive HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of First Positive HIV Test: _____/_____/_____	Ever Had a Negative HIV Test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	Date of Last Negative HIV Test: *(If date is from a lab test with test type, enter in Laboratory Data Section.)* _____/_____/_____
Number of Negative HIV Tests Within 24 Months Before First Positive Test *(#)*: _____ ☐ Refused ☐ Don't Know/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: _____/_____/_____	Date ARVs Last Taken *(mm/dd/yyyy)*: _____/_____/_____		

XI. Duplicate Review (Office use)

Status *(check one)*: ☐ Same As ☐ Different Than ☐ Pending	State Name:	STATENO:

XII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by:_____ Entry Date:_____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

LONG BEACH DEPARTMENT OF HEALTH & HUMAN SERVICES
2525 GRAND AVENUE, SUITE 229
LONG BEACH, CA 90815

TO DOWNLOAD THIS FORM, GO TO http://www.longbeach.gov/health/info_stats/hiv_reports.asp

TO REPORT THROUGH PHONE, PLEASE CALL (562) 570-4213. DO NOT SEND THE REPORT OVER THE FAX.

HIV Adult Case Report Form Instructions

*The purpose of filling out an Adult Case Report Form (ACRF) is to capture patient information as well as diagnostic information that will allow the case to be reported to the State.

The following information should be filled out on the form:

I. Health Department/ Reporting Facility
   a. Name, phone number, and the date the form is being completed.
   b. Physician's name, phone number, the name of the facility.

II. Patient Identification
   a. Their full name (last, middle, first).
   b. Address, phone number, and social security number.
   c. Medical record number and lab accession numbers can be placed in the other box.

III. Patient Demographics
   a. Sex assigned at birth, country of birth, DOB, vital status, status, race and ethnicity.

IV. Patient History
   a. MSM, MSW, IDU, heterosexual indications, and the "has the patient" section.

V. Laboratory Data
   a. Any labs performed on the patient should be indicated here.
   b. Check the type of test, the result, and the date the sample was collected.

VI. Clinical
   a. Indicate whether any AIDS defining diseases or Opportunistic Infections (OIs) exist and the date that disease was documented.

VII. Treatment/Services Referrals
   a. Has the patient been informed, and type of insurance.
   b. If the patient is female, indicate if she is currently pregnant and if she has delivered live-born infants.

VIII. HIV Testing and Antiretroviral use
   a. The source that produced the information and the date.
   b. Has the patient been previously diagnosed, and the date of diagnosis.
   c. Has the patient ever had a negative HIV test, and the date.
   d. Have they ever taken any ARVS and which ones, and the date of first use and when they were last taken.

IX. Duplicate Review

a. Fill this section in only if the patient is transferring care from another state.
b. Call CDC Help Desk (contact list on the W Drive) for the Out of State Number.
c. You will need a soundex for the last name, DOB, and the sex. (See HIV Investigations protocol).

X. Comments

a. Please note if this patient is transferring care from another city or state or returning to care. Any additional information you would like to include or are not sure where it belongs, please put it in the comments section.

CITY OF LONG BEACH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2525 Grand Ave. Long Beach, CA 90815 (562) 570-4302 FAX (562) 570-4374

Mauro Torno, MD
Interim City Health Officer

EPIDEMIOLOGY/
COMMUNICABLE DISEASE CONTROL PROGRAM

September 15, 2016

SUBJECT: REQUEST FOR PATIENT INFORMATION (RELEASE OF INFORMATION)

For the purposes of disease surveillance, prevention, and control efforts within the City of Long Beach, we are requesting additional patient information for a positive lab report for a **reportable communicable disease.**

By State law, HIV infection is a reportable condition in California. This requires laboratories, health care providers, and testing providers to report all cases of HIV infection to their local health department. This reporting requirement is necessary to timely monitor current trends in the epidemic, and to ensure continued funding by federal and State funding agencies for local AIDS treatment and HIV prevention services.

California Health and Safety (H&S) Code Section 121022(a) requires health care providers and laboratories to report cases of HIV infection by name to local health departments. H&S Code Section 121023(a) requires that all CD4 + T-Cell test results also be reported to the local health department. By law, and per State regulations, laboratories must report all CD4 + T-Cell test results and any HIV-indicative test, including all viral load results and confirmed antibody tests to their local health department **within 7 days**.

Laboratories located in Long Beach are responsible for reporting **all** CD4 T-Cell test results (not just those < 200/ul or < 14%), as well as any HIV-indicative test - including all viral loads (even if undetectable) and confirmed antibody tests - to Long Beach's Health Officer. The Health Officer's designee - HIV Epidemiology Program - will follow up with health care providers for laboratory reports sent in order to complete the HIV/AIDS registry.

Health care providers are responsible for providing the client's **full name**, date of birth and gender when submitting laboratory requisitions for any test used to identify HIV, a component of HIV, or antibodies or antigens to HIV.

Thank you for your assistance with this important public health matter. If you have questions, please contact Belinda Prado, HIV/STD Surveillance Supervisor, at (562) 570-4213. Please fax requested information to **(562) 570-4374**.

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for the public health investigation of communicable disease (Title 17, California Code of Regulations, Section 2500). Reliance on laboratory reporting is NOT a substitute. Under State laws, the reporting of communicable diseases to the local public health department is exempt from HIPAA (Section 164.512 (b)). **Patient consent is not required**. Patient information is always treated with strict confidence, and information requested is the minimum necessary for public health purposes.

COUNTY OF LOS ANGELES
Public Health

JONATHAN E. FIELDING, MD, MPH
Director and Health Officer

CYNTHIA A. HARDING, MPH
Chief Deputy Director

Division of HIV and STD Programs
Mario J. Pérez, Director
600 South Commonwealth Avenue, 10th Floor
Los Angeles, California 90005
TEL (213) 351-8000 • FAX (213) 387-0912

www.publichealth.lacounty.gov

April 18, 2014

RE: New HIV Testing Algorithm Reporting Requirements

Dear Laboratory Director,

California law requires that clinical laboratories report HIV-related tests from cases of HIV infection including positive HIV antibody tests, HIV genotype results and all viral load and CD4 test results. The Los Angeles County Department of Public Health (LAC-DPH) HIV Surveillance Unit has worked with local laboratories to establish efficient mechanisms to receive these HIV-related test results. We would like to bring to your attention the newly developed **HIV Laboratory Diagnostic Testing Algorithm** and its impact on HIV laboratory reporting.

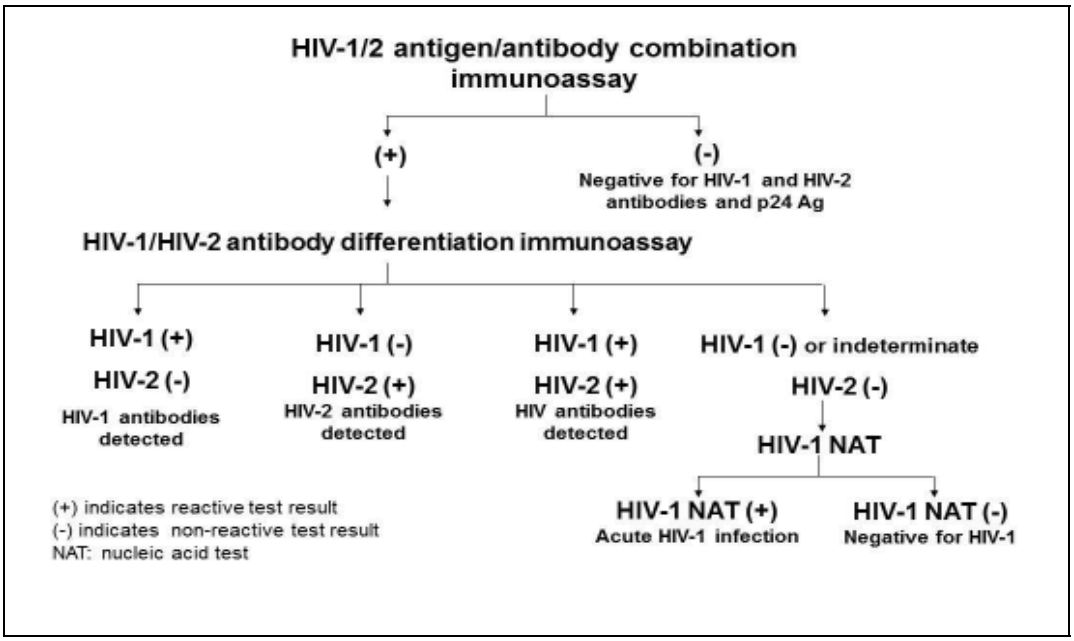
The new testing algorithm that has been recommended by the Centers for Disease Control and Prevention (CDC), the Association of Public Health Laboratories (APHL) and the Clinical and Laboratory Standards Institute (CLSI) [1-3] offers several advantages over the conventional algorithm, including the earlier detection of HIV infections and the ability to accurately classify HIV-1 and HIV-2 infections[4]. The use of this new HIV testing algorithm for California laboratories was approved by a California State Emergency Public Health Regulation in June 2013[5].

This letter provides information regarding the new testing algorithm and how to report test results to HIV Surveillance in accordance with the guidance put forth by APHL's HIV/Hepatitis Subcommittee report entitled "Suggested Reporting Language for the HIV Laboratory Diagnostic Testing Algorithm[6]."

A. Recommended HIV laboratory diagnostic testing algorithm for serum or plasma specimens

A flowchart of the new testing algorithm is shown below (Figure 1). This testing algorithm does not include the conventional Western blot or indirect immunofluorescence assay (IFA) confirmatory test. The algorithm starts with an initial 4th generation HIV-1/2 antigen/antibody combination immunoassay (HIV-1/2 Ag/Ab combo IA) – or a less sensitive 3rd generation HIV-1/2 immunoassay – which, if reactive, is followed by supplemental testing with an HIV-1/2 antibody differentiation assay. Specimens negative or indeterminate by the HIV-1/2 antibody differentiation assay will proceed with a qualitative HIV-1 nucleic acid test (NAT).

Figure 1: HIV Diagnostic Testing Algorithm



B. Interpretation of test results from the HIV testing algorithm and reporting to LAC-DPH

The following table describes the test result interpretation and guidance for reporting to the Los Angeles County Department of Public Health.

1st test: HIV-1/2 Ag/Ab IA	2nd test: HIV-1/2 Ab Differentiation IA	3rd test: HIV-1 NAT	Overall Interpretation	Reporting to LAC-DPH
Nonreactive	N/A	N/A	No laboratory evidence of HIV infection	Public Health reporting not required
Reactive	HIV-1 (+), HIV-2 (+) HIV-1 (+), HIV-2 (−) HIV-1 (−), HIV-2 (+) HIV-1/2 (+) undifferentiated	N/A	Laboratory evidence of HIV-1 and/or HIV-2 infection	Report 1st and 2nd HIV test results to Public Health
Reactive	HIV-1/2 (−) or indeterminate	Detected	***Acute*** or early HIV-1 infection	Report 1st, 2nd, and 3rd HIV test results to Public Health
Reactive	HIV-1/2 (−) or indeterminate	Not detected	HIV infection not confirmed; No laboratory evidence of HIV infection	Public Health reporting not required

In summary:

- Test results with a negative or inconclusive overall interpretation (indicating no laboratory evidence of HIV infection) should not be reported.
- All test results with a positive overall interpretation (indicating the presence of HIV infection) should be reported to the Department of Public Health. Please include all negative/nonreactive or indeterminate results that were performed as part of the testing algorithm (e.g., initial 4th or 3rd generation test result, HIV-1/2 differentiation test, and NAT).

The LAC-DPH HIV Surveillance Unit is working with the CDC to collect and document laboratory data from the new testing algorithm for HIV surveillance. We will continue to work with your laboratory to ensure complete, timely and accurate reporting of all HIV-related test results.

If you have any questions or would like assistance with reporting requirements for the new HIV testing algorithm, please contact:

- Zhijuan Sheng, HIV Surveillance Epidemiologist, at (213) 351-8767 or email: zsheng@ph.lacounty.gov
- Virginia Hu, Chief, Data Analysis Unit, at (213) 351-8140 or email: vhu@ph.lacounty.gov
- LaTonya Taylor, Chief Data Acquisition Unit, Lataylor@ph.lacounty.gov

Also, please find attached a list of LOINC codes for these new tests from the Centers for Disease Control and Prevention.

Sincerely,

Douglas Frye, MD, MPH
Chief, HIV Epidemiology
Division of HIV and STD Programs
Phone: (213) 351-8190

Attachment

References:

1. Laboratory Testing Guidance. Centers for Disease Control and Prevention. http://www.cdc.gov/hiv/testing/lab/guidelines/index.html. Accessed February 11, 2014.
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4. Branson, BM. The Future of HIV Testing. J Acquir Immune Defic Syndr 2010;55:S102-S105.
5. State of California Office of Administrative Law. Department of Public Health Emergency Regulatory Action. Approved June 26, 2013. http://www.oal.ca.gov/res/docs/pdf/emergencies/recent%20action,%20moved%20emergencies/2013-0617-01E_App.pdf. Accessed February 11, 2014.
6. Suggested Reporting Language for the HIV Laboratory Diagnostic Testing Algorithm. Association of Public Health Laboratories. Published November 2013. http://www.aphl.org/AboutAPHL/publications/Documents/ID_2013Nov_HIV-Reporting-Language.pdf. Accessed February 11, 2014.